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ABSTRACT

Homelessness is a troubling social problem, challenging to the best public and private efforts to provide some measure of remedy. For one group of the homeless, those with severe and persistent mental illness, that challenge is doubled: homelessness complicates the treatment of mental illness, even as mental illness complicates efforts to transition people from the streets to stable homes. Nine service demonstration projects were funded by the National Institute of Mental Health (NIMH), between April and July 1988 under the authority of the Stewart B. McKinney Homeless Assistance Act. These projects, the "Mental Health Services Demonstration Projects for Homeless Adults Who Are Chronically Mentally Ill" were designed to provide outreach, case management, mental health treatment, housing placement, and other services to homeless mentally ill adults in the nine local communities. The evaluation plan itself was to specify a strategy for developing systematic and analytic data on the nature and scope of services being provided. Technical site visits were completed. It was decided that the outcome portion of the national evaluation would not be attempted because of the very limited compatibility of the projects in limited client level outcome data that they were collecting. The final reports should be completed and available by the middle of 1992. One important conclusion seems certain at this point: many homeless, mentally ill persons will accept services and can be rehoused without extensive transitional programs. (LLL)

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THE NATIONAL EVALUATION OF THE NIMH/MCKINNEY SERVICES DEMONSTRATION PROJECTS[1]

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Homelessness is, by itself, a troubling social problem, challenging to the best public and private efforts to provide some measure of remedy. For one group of the homeless -- those with severe and persistent mental illness -- that challenge is doubled: homelessness complicates the treatment of mental illness, even as mental illness complicates efforts to transition people from the streets to stable homes. To target the problems of the homeless mentally ill is to take on the problem of homelessness in one of its most difficult forms.

Nine service demonstration projects were funded by the National Institute of Mental Health (NIMH), under the authority of the Stewart B. McKinney Homeless Assistance Act between April and July 1988. These projects -- the "Mental Health Services Demonstration Projects for Homeless Adults Who Are Chronically Mentally Ill" -- were designed to provide outreach, case management, mental health treatment, housing placement, and other services to homeless mentally ill adults in the nine local communities. The specific projects were selected by NIMH in May 1988, from over thirty proposals submitted by state mental health agencies on behalf of interested local communities. While the successful proposals were all devoted to a common mission, the approaches taken to that mission varied widely. The original project grants provided two years of funding, and seven of the nine projects received continuation funding for a third year. The nine projects were located in Chicago, Illinois; New York, New York; Flint/Ann Arbor, Michigan; Columbia, South Carolina; Portland, Oregon; Miami, Florida; Nashville, Tennessee; Cleveland, Ohio; and Richmond, Virginia.

What is impressive in reviewing the experiences of the projects is how much they have accomplished in a short time, working on such a difficult problem. Much more can, and will, be said about the accomplishments of these projects and their dedicated staffs. However, the topic of my presentation today is the "national" evaluation of this set of projects.

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[1]This paper was presented at the annual meeting of the American Psychological Association, San Francisco, August, 1991. The opinions expressed are those of the author and do not necessarily represent the official position of the National Institute of Mental Health. Correspondence concerning this paper should be addressed to the author at Room 7C06, 5600 Fishers Lane, Rockville, MD 20857.

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Design of the National Evaluation

The design of the National Evaluation was developed between August 1988 and May 1989 by Research Triangle Institute (RTI) under a task order agreement. The scope of work required the description of logic models for each of the projects, preliminary data on the implementation of the projects, development of a plan for conducting a national evaluation, as well as the provision of technical assistance to the individual grantees on their own local evaluations.[2] The evaluation plan itself was to specify a strategy for developing systematic and analytic data on the nature and scope of services being provided, detailing the extent to which the mental health and support services were coordinated within a coherent service system and were coordinated with other health and social services, and exploring the extent to which the target population was being served. It was also hoped that information could be developed that would allow for future studies of the effectiveness and impact of the demonstration projects. The Contractor was expected to coordinate the national evaluation activities with the local project evaluations and to work cooperatively with the projects in developing and implementing procedures and instruments for obtaining uniform service utilization data and client-level data across all nine projects.

A Request For Applications to conduct the actual implementation of the national evaluation was issued in July 1989. A two-year award was made in December 1989 to Abt Associates Inc. (AAI) and two subcontractors: Human Services Research Institute (HSRI) and Policy Research Associates (PRA) to conduct the national evaluation. Each of the members of the National Evaluation Team assumed primary responsibility for one of three components of the National Evaluation:

- PRA -- Technical Assistance
- AAI -- Implementation Evaluation
- HSRI -- Client Outcome Evaluation

The primary activity of the technical assistance (TA) component of the national evaluation involved conducting site visits to each of the projects for two purposes. First, and most importantly, the visits were seen as a way of bolstering the ability of the sites to conduct high quality evaluations. Second, the visits served to familiarize the sites with the national evaluation and gather important preliminary information on implementation and evaluation issues, including designs and measures being used in the local evaluations. A secondary activity of the TA component was the provision of ongoing technical assistance with evaluation activities throughout the two years of the contract.

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[2]The original RFA described in general terms a requirement that the projects conduct an implementation and outcome evaluation and cooperate with a national evaluation. It also specified that no more than 10% of the funds could be devoted to the evaluation. The RFA for continuation funding stipulated an increased emphasis on evaluation with a minimum of 15% to be devoted to evaluation.

The implementation evaluation had as its primary objective the description of the nine different projects based on a variety of sources of information including interviews and observations obtained through a site visit, descriptive information on the clients served and available services and previous reports by the projects and others. The implementation evaluation plan included several components, staged over a period of several months, to gather information on the implementation of each project and allow for integration of this information into a consistent format.

First, as discussed above, the technical assistance site visits provided an opportunity to familiarize the national evaluation team with the availability of various types of information concerning the implementation of the projects. The types of information sought included demographics of homeless mentally ill persons in the service area; a chronology/history of the program; budgets; project services, staffing, and organization; and key individuals (both within the project and in the local community) to be interviewed in later site visits.

Second, collateral materials were collected from state and local organizations (e.g., homeless coalitions, the Office of the Mayor, housing authorities) in order to understand the context in which each of the projects operated. These contacts produced a variety of information, including Comprehensive Homeless Assistance Plans, local planning documents, McKinney Mental Health Services for the Homeless (MHSH) Block Grant reports, local needs assessments of the homeless, U.S. census data on local population characteristics, supplemented with local data as available, and each project's original and continuation application.

Third, a four-day visit to each site with minimum of two visitors to each site was conducted. At a minimum, each of the site visit schedules included interviews with the state-level representative(s); project directors and supervisors; case managers and outreach team members; former members of the project staff; representatives from other agencies providing homeless services in the local area; and tours of the community, including areas where the homeless population congregate or live, homes where the homeless have been re-housed, shelters, and meal sites.

Fourth, prior to arrival of the site visit teams, each of the projects received a set of table shells. Three basic components of project implementation were covered by the information requested: project management and staffing; service delivery; and clients served. In total, the table shells requested a lot of information in a consistent format from each of the projects.

The client outcome evaluation, as originally envisioned, would have involved the selection of a core set of instruments for use by all of the projects, training in their use, and the collection of client outcome data at comparable intervals on all clients receiving services from the projects. The selection was to be based on measures already in use by the projects and done with the consultation and agreement of the individual projects. The training was

to be conducted in conjunction with the implementation evaluation site visits, and the data collection was to have occurred over a twelve month period from roughly mid-1990 to mid-1991.

Current Status of the National Evaluation

The initial design of the national evaluation was completed on schedule. The technical assistance site visits were completed and valuable information gained in addition to the technical assistance that was provided. The implementation site visits were conducted between July 16, 1990, through September 7, 1990 and produced some equally interesting and useful information on the projects. However, it was decided that the outcome portion of the national evaluation would not be attempted because of the very limited comparability of the projects and limited client-level outcome data that they were collecting. As a result, the second year of the national evaluation contract was not funded. Instead, the projects will individually provide any available information on client outcomes in their final reports. The final reports should be completed and available by the middle of 1992. A summary report based on all of the available information is planned and should be available in the Fall of 1992.

Observations on the National Evaluation

1. Despite the best intentions of all parties, a variety of circumstances resulted in an atmosphere in which limited respect and collaboration were possible between the national evaluation team and the local projects. The change in expectations about the local evaluation efforts, the delay in implementing the national evaluation, the limited role played by the local projects in the development of the national evaluation, and the many changes in NIMH and national evaluation personnel over time all contributed to a reticence on the part of the local projects to fully invest themselves in a national evaluation.

2. The decision to separately contract for the plan and the evaluation led to a number of problems that could have been anticipated. First, the extra time necessary to complete two separate procurements as well as the "rework" involved when a second contractor adapted the original design delayed the start of the national evaluation until well into the second year of the projects. By that time, it was almost impossible to even consider the development of common definitions of services or selection of common outcomes measures. Second, the local projects became confused about who was responsible for what with respect to the national evaluation. This problem was compounded by the fact that three separate groups were implementing distinct pieces of the national evaluation. It also generated the feeling on the part of project staff that they were spending inordinate amounts of time re-educating new groups of "outsiders" about their projects.

3. The very structure of the services demonstration "program" made the conduct of a national evaluation, regardless of how well it might have been designed and conducted, ill-conceived. To begin with, the concept of a national evaluation presupposes that there is a

program model (or limited set of models) implemented in a more-or-less comparable manner (i.e., with respect to clients, staffing, services, resources) in a reasonably large number of sites that can be thought of as "nationally-representative". Nine projects, concentrated east of the Mississippi, serving very different populations with different levels of staffing and resources, and different service mixes and philosophies do not a "national program" make.

4. The current environment creates strong pressures to produce summary (read national) generalizations about the impact of (or effectiveness of) programs such as this one. For example, the time is past when simple information on the number of people served and the types of services provided are deemed sufficient. All levels of government are demanding to know what happened to the recipients of services and whether it was worth the cost.

At the same time, the environment also contains constraints that make the type of national evaluation strategy employed in this case almost inevitable (assuming that any evaluation at all occurs). For example, uncertainty in year-to-year appropriations, and lack of clear authority to use "program" funds for evaluation, makes planning of evaluations before projects begin extremely difficult. It also jeopardizes any ongoing commitments to evaluation. The administrative difficulties (and costs) in mounting the type of large, multi-year, data collection activities needed for sound evaluations of effectiveness are daunting.

Conclusion

The picture just painted of the national evaluation of the McKinney Service Demonstration Program would appear to offer little in the way of hope for those who had hoped for a mandate to expand comprehensive service programs for this population. However, I think that once all of the projects are completed and the final chapter can be written, there will be ample evidence on which to base some important conclusions about structuring services for this population. Developing those conclusions will require a sensitive reading and analysis of the numerous sources of information that have been generated by, and about, the projects. The nature of those conclusions will, in all likelihood, be related to the need for, and acceptability of, various services and service arrangements by the homeless mentally ill population. However, one important conclusion seems certain at this point: many homeless mentally ill persons will accept services and can be rehoused without extensive transitional programs. On the other hand, accomplishing this does require intensive support that is offered to the individual on their own terms.